

State of California  
Department of Industrial Relations  
Self Insurance Plans  
2265 Watt Avenue, Suite 1  
Sacramento, CA 95825  
Web site <http://sip.dir.ca.gov>  
E-mail: [sip@dir.ca.gov](mailto:sip@dir.ca.gov)

PUBLIC SELF INSURER’S ANNUAL REPORT  
FOR NON-JPA MEMBER

I. GENERAL

1. CERTIFICATE NUMBER:

-  -  -

☐ Active      ☐ Revoked

2. PERIOD OF REPORT:

☐ Full Year      ☐ Interim/Amended Report for the Period of:  
 to   
Month Day Year      to      Month Day Year

3. NAME OF MASTER CERTIFICATE HOLDER:

\_\_\_\_\_

Federal Tax Identification No.: \_\_\_\_\_

\_\_\_\_\_  
Address of Main Headquarters

\_\_\_\_\_  
CITY STATE ZIP + 4

4. TYPE OF PUBLIC AGENCY:

<input type="checkbox"/> CITY/COUNTY	<input type="checkbox"/> POLICE/FIRE	<input type="checkbox"/> TRANSIT
<input type="checkbox"/> SCHOOL	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> OTHER

5. During the period of this report, has there been any of the following with respect to the master certificate holder, subsidiary or affiliate certificate holder?

A merger or unification?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Change in name or identity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any addition to Self Insurance Program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

6. Are there any agency employees NOT included in your Workers’ Compensation Self Insurance Program?

☐ Yes      ☐ No

If yes, what employees are not included? \_\_\_\_\_  
\_\_\_\_\_

Are these employees covered by an insurance policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are these employees covered by another self insurance cert. or JPA?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP + 4: \_\_\_\_\_

TELEPHONE: (    ) \_\_\_\_\_ FACSIMILE (FAX): (    ) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

8. CERTIFICATION BY AGENCY OFFICIAL:

I declare under the penalty of perjury that I have examined this Self Insurer’s Annual Report and to the best of my knowledge and belief it is true, correct and complete.

Signature (Original Only): \_\_\_\_\_ Date: \_\_\_\_\_

Typed Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

Fiscal Year  
02/03

## II. CONSOLIDATED LIABILITIES

Certificate Number: ---

Name of Master Certificate Holder: \_\_\_\_\_

Type of Report:

☐ **Original Report** (Due October 1 each year)☐ Interim/Amended Report for the Period of:

Month Day Year to Month Day Year

### A. CASES AND BENEFITS (to nearest dollar)

		Incurred Liability		Paid to Date		Future Liability	
	Number	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 6/30/2003 reported prior to FY 1998-99							
<b>2. Open &amp; Closed Cases:</b>							
a. FY 1998-99 Total cases reported							
b. FY 1999-00 Total cases reported							
c. FY 2000-01 Total cases reported							
d. FY 2001-02 Total cases reported							
e. FY 2002-03 Total cases reported							
<b>SUBTOTAL</b>						\$ Indemnity	\$ Medical
<b>3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)</b>							
<b>TOTAL</b>							
<b>4. Total Benefits paid during FY 2002-2003 (include all case expenditures):</b>						\$ Indemnity	\$ Medical

**4. Total Benefits paid during FY 2002-2003 (include all case expenditures): . . . . .**

**5. Number of MEDICAL-ONLY cases reported in FY 2002-2003: .....**

**6. Number of INDEMNITY cases reported in FY 2002-2003: .....**

**7. TOTAL of 5 and 6 (also enter in 2e above):** .....

**8. TOTAL number of open indemnity cases (all years):** .....

**9. Number of Fatality cases reported in FY 2002-2003:** .....

**10. (a) Number of FY 2002-2003 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2002-2003: . . .**

(b) Number of non-FY 2002-2003 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2002-2003: . . .

**B. TOTAL EMPLOYMENT AND WAGES PAID IN FISCAL YEAR 2002-2003  
FOR THIS SELF INSURER:**

**(a) NUMBER OF EMPLOYEES** \_\_\_\_\_  
(Number of individual employees listed on Form DE-6 for year ending June 30, 2003)

**(b) TOTAL WAGES AND SALARIES PAID \$ \_\_\_\_\_**  
(As reported on EDD Form DE-6 Line M for all four quarters)

**Fiscal Year**  
**02/03**

IIA. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or Self Administered

City

State

Zip+4

2. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or Self Administered

City

State

Zip+4

3. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or Self Administered

City

State

Zip+4

4. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or Self Administered

City

State

Zip+4

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THIS REPORTING PERIOD? YES NO IF YES, DATE OF CHANGE:

TYPE OF CHANGE:

Change in Administrative Agency

Change to or from Self Administration

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name

Agency Name

Address

City

State

Zip+4

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

Original Signature of Administrator (Person)

Date

Typed Name of Administrator

Phone No. of Administrator

Title

Fax No. of Administrator

Name of Administrative Agency or Employer

E-mail Address of Administrator

Street Address

City

State

Zip+4



**NOTE: Claims Administrator**  
Complete this page for *each adjusting location* where there are at least two adjusting locations.

III. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.:     -  -  -

Name/Identification of Location:    \_\_\_\_\_

OR

Name of Affiliate/Subsidiary Certificate Holder:    \_\_\_\_\_

Type of Report:

☐ **Original** Report (Due October 1 each year)

☐ Interim/Amended Report for the Period of:

Month    Day    Year

to    Month    Day    Year

**A. CASES AND BENEFITS** (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 6/30/2032 reported prior to FY 1998-99							
2. Open & Closed Cases:							
a. FY 1998-99 Total cases reported							
<div>FY 1998-99 Cases open</div>							
b. FY 1999-00 Total cases reported							
<div>FY 1999-00 Cases open</div>							
c. FY 2000-01 Total cases reported							
<div>FY 2000-01 Cases open</div>							
d. FY 2001-02 Total cases reported							
<div>FY 2001-02 Cases open</div>							
e. FY 2002-03 Total cases reported							
<div>FY 2002-03 Cases open</div>							
SUBTOTAL						\$ Indemnity	\$ Medical
TOTAL						\$ Indemnity	\$ Medical
4. Total Benefits paid during FY 2002-2003 (include all case expenditures): . . . . .							

5. Number of MEDICAL-ONLY cases reported in FY 2002-2003: . . . . .

6. Number of INDEMNITY cases reported in FY 2002-2003: . . . . .

7. TOTAL of 5 and 6 (also enter in 2e above): . . . . .

8. TOTAL number of open indemnity cases (all years): . . . . .

9. Number of Fatality cases reported in FY 2002-2003: . . . . .

10. (a) Number of FY 2002-2003 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2002-2003: . . . .

(b) Number of non-FY 2002-2003 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2002-2003: . . . .

Fiscal Year

02/03

III.A. ADMINISTRATOR

A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) AT THE TIME OF PREPARING THIS REPORT.

1. Name (Person)

Administrative Agency's

Agency Name

Certificate No.:

Address

or

Self Administered

City

State

Zip+4

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ YES ☐ NO IF YES, DATE OF CHANGE:

MonthDayYear

TYPE OF CHANGE:

☐ Change in Administrative Agency

☐ Change to or from Self Administration

C. NAME OF PRIOR ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name

Agency Name

Address

City

State

Zip+4

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this consolidated report of this self insurer’s workers’ compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers’ compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers’ compensation claims made in this report reflect the administrator’s best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

Original Signature of Administrator (Person)

Date

Typed Name of Administrator

Name of Administrative Agency or Employer

Title

Street Address

City

State

Zip+4

Phone No. of Administrator ( )

Fax No. ( )

area code

area code

E-mail Address of Administrator



IV. RECORDS STORAGE

1. Are claims records stored at any location other than with the current administrator?

☐ Yes    ☐ No    If yes, Where? \_\_\_\_\_

A. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____	C. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____
B. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____	D. Agency Name _____ Address _____ City _____ State ____ Zip+4 _____ Phone (____) _____

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

☐ Yes    ☐ No    If Yes: \_\_\_\_\_

1. Name of Insurance Company: _____ Policy Number: _____	Policy Issue Date: _____
2. Name of Insurance Company: _____ Policy Number: _____	Policy Issue Date: _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

☐ Yes    ☐ No    If Yes: \_\_\_\_\_

1. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____
2. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

☐ Yes    ☐ No    If Yes: \_\_\_\_\_

1. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____
2. Name of Carrier: _____ Policy Number: _____ Retention Limit: _____	Policy Issue Date: _____

VI. OPEN INDEMNITY CLAIMS

A. List of ALL Open Indemnity Claims by reporting location and by year reported and with claims in alphabetical order is attached immediately following page 6 of this report.  
(You may use the form attached or a computer-prepared printout organized in the same format.)



## VII. FUNDING OF LIABILITIES

Certificate Number: ---

Name of Certificate Holder: \_\_\_\_\_

**1. Which of the following best describes the method your agency uses to fund the outstanding workers' compensation liabilities?**

- ☐ Actuarial Basis
- ☐ Cash Flow Basis
- ☐ Fixed Amount in Agency Budget—Amount is:    \$ \_\_\_\_\_
- ☐ Percentage Above Last Year's Losses—Percentage is: \_\_\_\_\_ %  
—Total Amount Available is:    \$ \_\_\_\_\_
- ☐ Agency Does Not Fund Workers' Compensation Liabilities
- ☐ Other: \_\_\_\_\_

2. Does your agency fund for incurred but not reported workers' compensation claims in addition to known or reported claims?

- ☐ Yes      ☐ No      If yes, Amount: \$ \_\_\_\_\_

**3. Is the workers' compensation funding restricted or set aside solely to pay the agency's workers' compensation liabilities?**

- ☐ Yes      ☐ No

If yes, what was the amount set aside as of June 30, 2003? \$ \_\_\_\_\_

4. Does your agency have an outside, independent claims auditor review your case reserve practices and general claims management?

- ☐ Yes      ☐ No

If yes, what was the date of the last such audit? \_\_\_\_\_

**5. Does your agency have an outside, independent actuary to review future liability funding?**

- ☐ Yes      ☐ No

If yes, what was the date of the last such review? \_\_\_\_\_

**Fiscal Year**  
**02/03**

LIST OF OPEN INDEMNITY CASES  
AS OF \_\_\_\_\_  
(Date)

Reporting Location No.: \_\_\_\_\_

All Cases on this Page are  
For the Year \_\_\_\_\_

Certificate Number: \_\_\_\_\_

NAME OF MASTER CERTIFICATE HOLDER: \_\_\_\_\_

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Labor Code Section 4850 Salary	Description of Injury	Paid to Date		Estimated Future Liability	
				\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
(List Alphabetically within year)							

Fiscal Year  
02/03